NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF EMERGENCY MEDICAL SERVICES

APPLICATION FOR EMT TRAINING FUND COMPUTER PROGRAM

TYPE OR PRINT ALL INFORMATION.

Name of Squad	
Street Address	
Mailing Address (if different)	
City, State, Zip Code	County
Name of Contact Person	Telephone Number ( )
Title of Contact Person	Federal ID Number
Shipping Address City	State Zip Code
Name of Receiving Agent	Telephone Number ( )
Signature	Date

Status of Squad

☐ Recognized First Aid or Rescue Squad

Non-Billing ☐Yes ☐No

CERTIFICATION:

The applicant certifies that to the best of his/her knowledge and belief all data supplied in this application are true and correct. The applicant understands and agrees that the computer(s) should be returned to the Department of Health and Senior Services when the computer(s) are no longer needed by the Squad. The applicant understands and agrees that acceptance does not obligate the State to replace the machine if it should be broken.

Name and Title of Applicant (Print)	
Signature	Date of Application

FOR STATE USE ONLY	
☐ Approved	☐ Disapproved

EMS-58
MAR 03